

Signs of Mental Health



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Alabama Department of Mental Health
Office of Deaf Services
P.O. Box 301410, Montgomery, Alabama 36130



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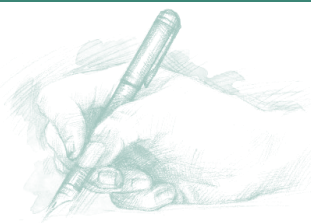
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On The Cover:

Just for fun, a simple cover with no tale to tell other than a fervent hope all of our readers have a wonderful holiday season

Editor's Notes



We like getting letters. Since the last issue we received a few that really warmed our hearts. One was from our old friend, Ben Karlin. Ben, along with Kelley Clark, were the co-conspirators with Steve Hamerdinger in developing what eventually became the *Qualified Mental Health Interpreter* concept.

Just saw the advertising with next August's MHIT dates. You should be forewarned that my son is planning to go. You will recognize him immediately: he's the smart alec and know-it-all. We've been told it is almost as though he is my twin. I guess we also have a family resemblance but he is bigger, younger, hairier and stronger than I. I think I may still be the louder and, while he, quicker-witted, I may still have an edge in funnier. He makes up for it in LPM (laughs per minute) so has more quantity where I still shoot for quality.

You'll enjoy having him there and after all, isn't that really the point of a class like MHIT?

Sometimes I feel like a stalker following you and the department online as news, workshops, and writing bubble to the surface on the internet from time to time and place to place. Be assured I do not google your home addresses or hang out in bushes watching through windows or anything any more stalkerish like that. Just come across a familiar name here and there. Sometimes it makes me wistful — is that the right word? Looking back, I wish I'd done work with more impact or permanence, but mostly it makes me proud of whatever contribution I did make to the lives of the clients I worked with. I am pleased for you folks, knowing you as colleagues, and proud of the work you are doing.

Having seen how miserable life can be for deaf clients and how it can sometimes get even worse when they have interpreters without training, strong ethical and moral reasoning, and sharp self-monitoring, I am so grateful you are carrying on with the training and educational work you have done now for, believe it or not, a long time! I miss so many friends and colleagues from the field. I miss the mentors and the lively debates on what is right and, since we so rarely could do that, what is the best service we could provide. I miss learning from people who knew their fields better than I knew mine and were not threatened by questions.

The field has grown up so much since I did my first literature review in 1997. There is maturity to it as well as brilliance all around the table at conferences regarding Deaf people and mental health. It is still difficult to find literature on interpreting in the field. I know you join me in hoping we move beyond interpreting in therapy to interpreting in treatment team meetings and then back gracefully

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Thornsberry Joins ODS Staff as Regional Therapist



The newest staff member to join the Office of Deaf Services, Kimberley Thornsberry, started as a regional therapist November 17th, filling the position vacated by Lance Weldgen who left for a position in Indianapolis.

Kim, as she prefers to be called, is now working at the Office of Deaf Services Huntsville. Her responsibilities are to provide direct services to individuals who are Deaf and Hard of Hearing.

Although Thornsberry is originally from Michigan, she considers Alabama her second childhood home. She visited often with her father, an Alabama native, during summertime and Christmas while growing up.

Thornsberry, who is deaf herself, attended Gallaudet University in Washington, DC where she graduated with a Bachelor of Arts in Psychology and a Bachelor of Science in Family and Consumers Studies with a specialization in child development. She then moved to Oregon to attend Western Oregon University where she obtained her master's degree in Rehabilitation Counseling with the Deaf. She has also pursued several Mental Health counseling related courses through the University of Utah to meet the qualification for Clinical Mental Health Counseling (CMHC) licensure in Utah. She currently holds Certified Rehabilitation Counseling (CRC) certification and is in the process of obtaining Associate Licensed Counselor (ALC) certification in Alabama.

Prior to accepting the therapist position with ODS, Thornsberry worked as Transition Specialist in Mesa, Arizona for a year and then as Case Manager/Advocate for the Deaf and Hard of Hearing in Salt Lake City, Utah for 7 years. "I am passionate about working with individuals who are Deaf, Hard of Hearing, and Deafblind. I have heard many positive things about Office of Deaf Services with Alabama Department of Mental Health and Mental Health Interpreting Institute." She told **SOMH**. "I feel really honored to be part of this wonderful team! I hope to expand my counseling skills, learning to apply Communication Assessment profiles, and provide good quality services to individuals who are Deaf and Hard of Hearing. I have always considered advancing my professional opportunities and give back by teaching and training future professionals how to work with Deaf, Hard of Hearing, and Deafblind consumers in human service settings effectively."

Thornsberry is also involved with the Deaf Self Advocacy Training [\(DSAT\)](#) curriculum as one of the fourteen Master Trainers through the National Consortium of Interpreter Education Centers. Since 2010, this project has provided training to consumers as well as offering "Train the Trainer" courses to those who

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Deaf Services Staff Double As Santa's Helpers

For the fourth year in a row, members of the Alabama Deaf Community participated in a gift program for Deaf people who have mental illness and are living in various residential programs around the state. This year, the project was coordinated by Shannon Reese.

There are as many as 28 people who could be in long-term care beds at any time. Often these people have little or no contact with family members. For them, the winter holidays can be a dismal time of year. The project has a goal of making sure that everyone in long-term care who is deaf have at least one present.



This year, 23 different people or organizations took part in collecting gifts for the 27 recipients who benefited this season. (For a report on last year's effort, see the winter 2014 issue, Volume 11, Number 1.)

The project grew out of an annual effort to make sure that people who were living on the now defunct Bailey Deaf Unit, had some kind of celebration. Even though Greil Hospital participated in Mental Health America's Operation Santa Claus, the people served by the Deaf Unit were unique. Unlike those in the general population, who were largely local to the Montgomery area, Deaf Unit residents came from all over the state. Many of them were far from their families, if they even had any family involved in their lives. When the unit closed in 2010, the former residents were largely scattered to residential programs set up around the state.

The same issue of limited contact with family remained even when consumers moved into community placements.

When one of the ODS therapists asked a consumer if they were looking forward to Christmas, she replied that she wasn't. No one would visit her and no one would send her any presents. "At BDU I got presents. Now I get nothing," she said. That conversation, brought up in a clinical meeting one day, triggered the idea of collecting gifts for every deaf person in a residential program under Deaf Services. Then statewide psychologist Dr. France Ralston quickly volunteered to lead the effort.

Every year since 2010, ODS has made it a mission to ensure that every deaf person with mental illness in a residential program would be able to look forward to the holiday.

Today, the effort is a partnership between ODS and Friends of Deaf Services (FODS), a project of the Alabama Association of the Deaf (AAD). Its mission that goes beyond just the holidays. It is committed to providing support to mentally ill deaf people who are in need of a helping hand. Sometimes it is clothing. Sometimes it is help covering costs of moving into an apartment on their own. Each year, FODS sponsors an outing for group home residents.

Contributions to FODS are tax deductible and will be used specifically to provide things deaf consumers need – things that aren't covered by group home funding or Medicaid, or any other funding source. If any reader is interested in making a donation, they should contact AAD treasurer Rann Gordon at wmgordonjr@gmail.com. ✂



Left: Shannon sorts through a cubicle full of holiday cheer for Deaf consumers. Top Lee Stoutamire is making a list and checking it twice. Bottom: ODS staff clockwise from bottom left; Shannon Reese, Charlene Crump, Katherine Anderson, Lee Stoutamire, Scott Staubach, Kim Thornsberry, Dawn Vanzo, Wendy Darling, Sereta Campbell, Vyron Kinson

Guest Article Review: *Intersections of culture and power in clinician and interpreter relationships: A qualitative analysis*

Becher, E. H., & Wieling, E. (August 4, 2014). *The Intersections of Culture and Power in Clinician and Interpreter Relationships: A Qualitative Study*. *Cultural Diversity and Ethnic Minority Psychology*. Advance online publication. <http://dx.doi.org/10.1037/a0037535>

By Bethany Batson, BA., NIC



"I don't want this little white girl to mess up what I have to say!" angrily signed my consumer to his service provider as we walked into her office. It is always uncomfortable to interpret comments about myself while working, but especially when the comment is so defamatory. Any interpreter who has experienced similar cultural clashes while working understands what an

influential role culture can play in the outcome of an assignment. But do culture and power also have an influence in the clinician and interpreter relationship? Emily Becher and Elizabeth Wieling attempt to shed light on the question in their research article *The Intersections of Culture and Power in Clinician and Interpreter Relationships: A Qualitative Study*, published in *Cultural Diversity and Ethnic Minority Psychology* (August 4, 2014)

The aim of their article was to assess how facets of power and privilege influence the relationship between English speaking clinicians and professional interpreters in mental health settings. An interpreter is often required for effective communication when a clinician and patient do not share proficiency in a common language. Without interpreters the inequalities of healthcare and mental health services for minority groups would be even more exaggerated than they are presently. Using interpreters, however, adds a level of complexity to the clinical encounter that is not present when the therapist and patient can communicate directly.

Interpreters were previously viewed as merely a linguistic bridge and little else. They were expected to be mechanical and aloof. More recently, however, the spectrum of what interpretation means has broadened to what Becher and Wieling, as well as other researchers, call a "cultural broker." Cultural brokering means that an interpretation may need to include appropriate cultural information to make the communication and understanding between the involved parties clear. Ideally, this enhances the understanding of

those involved, but there are also reports that cultural brokering can produce problems and gray areas. If the clinician perceives that the interpreter is overstepping their professional responsibility it can lead to negative outcomes in the overall encounter. These problems have mostly been attributed to an overall lack of training in the interpreting profession as well as a lack of appreciation for the complexity of the interpreter's work.

Interpreters and therapists agree that the best framework for effective cross-language therapy is a relationship that is collaborative and based on trust. Becher and Wieling admit that relationships between therapists and interpreters is under studied, but that relationships are critical to positive outcomes in therapy settings. Like all relationships, personal biases can unintentionally affect the budding relationship between clinicians and interpreters and consequently affect the clinical encounter as a whole.

In addition to biases, perceived power and privilege can influence the relationship between service providers. North American culture often perceives clinicians as "experts" while interpreters are viewed as "ancillary" and "interchangeable." Despite large bodies of literature recommending the use of the same interpreter over the course of a patient's treatment, it rarely ever happens. Hospitals and clinics are prone to hiring interpreters on an "as-needed" basis, and many interpreting agencies do not make an effort to provide the same interpreter for each session between a given consumer/clinician set.

Even with a qualified interpreter present, communication does not always flow smoothly, and the interpreter is often the first person blamed. They may be interpreting very well and acting as a cultural broker, but if in doing so, they present information that is contrary to western ideology, they are in what Becher and Wieling call a "hierarchically disadvantaged role." This puts them in an unfortunate place, because that same information could be offering nuances of meaning which could enhance the cultural awareness and competence of the therapist. A therapist with cultural competence could lead to better outcomes for the patient. Since North American culture gives more hierarchical power to the clinician or therapist, it is thought that their perspective (i.e. world view, culture, values, etc.) will be acknowledged as truth. This hypothesis warrants further research, especially given the discrepancies in effective mental health services for minority groups. The hypothesis also suggests that better outcomes would result if there were greater freedom to exchange cultural information between the interpreter and clinician.

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From the ODS Case Files:

Challenging Cases, Creative Solutions

Grand Rounds: Case Presentation #5 (*Identifying information including names, settings etc. have been altered for the privacy of those involved*)

Sometimes communication assessments and observations provide a clear picture of the person's language abilities and weaknesses. This helps to differentiate lack of language exposure from language related issues tied to cognitive abilities or mental illness. Sometimes there are such a myriad of possibilities that teasing out one potential cause from the other can become difficult.

The Case

Jane isn't the kind of consumer who has language deficiencies so severe that you immediately insist on a certified Deaf Interpreter (CDI)/Communication Specialist. Upon first meeting her, cognitive deficiencies aren't obvious. She seems young, somewhat shy, and pleasant. The typical deaf person raised in an inadequate mainstreamed environment without adequate language support at school or home, an over emphasis on speech and hearing aids/cochlear implants as desired language outcomes. She has a history of behaviors that include getting into arguments with friends because someone was talking about her, getting upset and running away. Each of these areas have a cumulative impact on service provision.

Jane is a 19 year old Caucasian female with a bi-lateral profound hearing loss. She reports the cause of deafness is due to Meconium Aspiration Syndrome (MAS) at birth. (See box next page)

Jane was mainstreamed in public schools from Kindergarten through 8th grade. Jane transferred to the School for the Deaf at the beginning of her 9th grade year. She repeated 8th grade her first year there and graduated in 2013 at the age of 19.

Jane received a cochlear implant when she was five years old and reports the cochlear implant as being beneficial. She states she is a "good lipreader" and demonstrated the ability to effectively speechread common phrases such as "How old are you," "What is your name," and "When is your birthday?" She uses speech in most of her responses and can be understood in conjunction with the sign. Her speech alone is not readily understood by most hearing people. There are significant misunderstandings when the information becomes more

complicated and detailed. Neither speech nor speechreading appear to be a viable option for therapy.

She is the only Deaf member of her family. Her mother and sister know and use limited sign language. The mother primarily speaks to Jane and adds an occasional sign during communication. Jane defers to her mother most often for responses when her mother is present.

Communication through reading/writing is limited and not sufficient for complicated or detailed conversations or information sharing.

Jane prefers to communicate through the use of sign language.

Observations Related to Language (*As demonstrated through her BEST language - Sign Language*)

- Responses are brief and often derailed.
- Sign production is clear but not native like.
- Receptive ability is limited to very concrete concepts and requires much expansion from the interpreter of concepts or questions.
- Therapist/interpreter must check back to assure that Jane has understood even the most simple of concepts/questions. Often when asked to repeat back comments (even those related to her own experiences), she cannot.
- Becomes embarrassed when a concept cannot be understood or when she isn't giving the "right" answer. Often smiles and nods. Appears uncomfortable, somewhat nervous (constant shaking of her left leg) and easily distracted.
- Does not incorporate many, if any, ASL grammatical features in her language.

Discussion

This case is particularly difficult because there are numerous considerations:

- Lack of adequate language exposure and inadequate language support system
- Limited fund of information
- Presence of developmental disability
- Naïve, immature
- Desire to please others with communication needs.
- Inability to assess her own language strengths.
- Will not let others know when she does not understand

Has developed many coping strategies/survival skills related to covering up that she does not understand.

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From ODS Case Files

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Her presence, friendliness and willingness to please others can inadvertently and perhaps naively lead people to believe that she has some hearing ability and can speechread adequately and therefore does not require an interpreter. Especially complicating the issue is that even when an interpreter or sign fluent therapist is present, her responses are often off the mark and require a great deal of work on the part of the interpreter/therapist to make questions sequential, pictorial, specific, concrete and simple.

Recommendations

Utilization of a sign fluent therapist or a qualified sign language interpreter working with a therapist familiar with deaf consumers.

Establish a system for Jane to let individuals know when she is understanding/not understanding. (such as "Green – I'm understanding fine"; "Yellow – I think I understand what you mean" and "Red – I do not understand"). This will help give feedback to the therapist/interpreter on when/where she is and is not understanding. This can be incorporated into her therapy which may help resolve some conflict in her personal life as well, if she can transfer these skills.

Check back frequently to for understanding. Have her repeat information just stated or respond to it (How do you feel about that? What happened next?)

Utilize pictures as reminders/markers of conversation. This can assist with sequencing. (Example: pictures of the following - school, cafeteria, friends, fight, run away) can show the sequencing of events for the topic of therapy discussion. The pictures can be referred back to, reminding her of what the topic is or what of the story the question is referring to.

Consider the use of role play to have her actively participate in effective/ineffective responses. ✎

Laughter is the Best Medicine

Both "Oppositional Defiant Disorder" and "Conduct Disorder" include parental neglect or "lack of supervision" among the diagnostic factors. As a layperson looking at those factors, it looks to me like approximately 100% of adolescents have Oppositional Defiant Disorder ("is often angry and resentful," "often argues with adults," "often deliberately annoys others"). Also, I think I have it. – Kevin Underhill, Esq.

Meconium Aspiration Syndrome

Meconium aspiration syndrome occurs when a newborn baby breathes a mixture of meconium and amniotic fluid into the lungs around the time of delivery. It is a serious condition.

Causes

Meconium is the early feces (stool) passed by a newborn soon after birth. In some cases, the baby passes meconium while still inside the uterus. This will happen when babies are "under stress" because the supply of blood and oxygen decreases. This is often due to problems with the placenta.

Once the meconium has passed into the surrounding amniotic fluid, the baby may breathe meconium into the lungs. This may happen while the baby is still in the uterus, or still covered by amniotic fluid after birth. The meconium can also block the infant's airways right after birth. It can cause breathing problems due to swelling (inflammation) in the baby's lungs after birth.

Risk factors that may cause stress on the baby before birth include:

- "Aging" of the placenta if the pregnancy goes far past the due date
- Decreased oxygen to the infant while in the uterus
- Diabetes in the pregnant mother
- Difficult delivery or long labor
- High blood pressure in the pregnant mother

<http://www.nlm.nih.gov/medlineplus/ency/article/001596.htm>

Most babies with uncomplicated MAS improve within a few days or weeks, depending on the severity of the aspiration. Some studies, however, suggest that those born with MAS are at a higher risk of developing an asthmatic-like condition.

Severely affected babies have a much more guarded prognosis; they may develop chronic lung disease, **developmental abnormalities and hearing loss**. Sometimes very severe cases of MAS can be fatal.

<https://www.luriechildrens.org/en-us/care-services/conditions-treatments/meconium-aspiration-syndrome/Pages/index.aspx>



News item:

Suspect arrested in the death of woman murdered at complex for the hearing impaired



MOBILE, Ala. (WALA) – Mobile police have arrested a suspect in connection with the murder of a 55-year old woman Wednesday.

23-year-old Myles Xavier Smith was taken into custody shortly after 5:00 p.m. Smith is charged with Murder and Possession of a Controlled Substance.

Police were called to the Onderdonk Cottages around 3:20am Wednesday. They found the victim lying in the middle of the parking lot just a few yards from her apartment. She was rushed to the hospital where she died. No one knows why she was out at that time of the morning, or who would want to hurt her.

Lana Stephens said she had her hearing aid on because she was awake and on the computer.

"I was doing the internet, and I heard something. I thought it was some kind of a back fire," Stephens said.

That noise turned out to be gunfire, and the victim was Stephen's neighbor.

"I was looking through the window and there was seven cop cars parked in here," she said.

Everyone in the complex, including the victim has some form of hearing loss.

<http://fox10tv.com/2014/12/03/woman-murdered-at-complex-for-the-hearing-impaired/>

I have written in these pages before about how the department of Housing and Urban Development (HUD) Section 8 rules make it nearly impossible to have an apartment complex where all the residents are deaf. (See Volume 11, number 1, page 9.) To say that at Onderdonk "everyone in the complex... has a hearing loss," is stretching the truth. A few residents are Deaf. Most are not. There are many who are not even hard of hearing. No matter what the media says.

The complex was built to meet the needs of deaf people – especially those who use American Sign Language as their primary or only language. In the beginning, staff hired to work there had to be ASL-fluent. This was a cozy linguistic community in Mobile that incidentally served deaf people with additional needs, such as wrap around services to help them live with mental illness or intellectual disabilities.

But things changed. Our ever wise Federal government stepped in and said, "No you can't do that. You will create a disability ghetto." So this establishment, which was meant to be a safe haven for a greatly oppressed linguistic minority, had to open its doors to anyone who qualifies for Section 8 vouchers. The "safe haven" soon became a dangerous, drug-infested, crime-ridden location where many deaf people living in Mobile are afraid to go. Staff are no longer required to be able to sign... at all. It has become so bad that AltaPointe, which serves many deaf people with mental illness, will not recommend deaf consumers live there.

Unfortunately, that does not mean that none of our consumers are there. There are a few. And they were exposed to a murder. They saw a body lying on the parking lot pavement, blood running down the driveway.

They were traumatized and then, because there were so few ASL - fluent deaf in the complex, they were unable to support each other. Before HUD, there would have been more deaf people and there have been ASL – fluent staff there to assist in coping with the tragedy. The HUD directives changed that. Now there are no sign-fluent staff there to help. They were questioned by law enforcement and the media... but no interpreters were called. But the system was happy to allow one of the consumers there to "interpret".

And so, another government edict, another deaf program dismantled, and another safe haven lost. "But we have to scatter deaf people so they don't become ghettoized!" Yeah, right. And isolate deaf people from each other where they can no longer provide mutual support.

Where to begin...

(Continued on page 11)

Article review

(Continued from page 5)

Most staff-interpreters voiced that they felt “empowered” and “respected” by therapists and clinicians. However, most agency-based interpreters felt they had to “maintain strong professional boundaries.”


Their research is organized into three categories: (1) “Interpreters Speaking Out,” (2) “The Relationship Matters,” and (3) “Who Has the Power?” In the first category, “Interpreters Speaking Out” there were a variety of discordant opinions voiced. Many interpreters and clinicians preferred the interpreter to feel empowered to voice information that they felt would be appropriate and beneficial to the clinical encounter. Interestingly, both interpreters who felt it was appropriate to include pertinent information (in addition to the interpreted message) and interpreters who did not feel it was appropriate cited maintaining ethical practice as the reason for their opposing choices. Although most clinicians appreciated interpreters acting as a cultural broker, some reported feeling uncertain as to what they should do if the interpreters went too far. They reported that sometimes cultural brokering could become inappropriate if the interpreter began having independent conversations with the patient or were thought to be interpreting the message incorrectly. Whether the clinician positively or negatively reacted to an interpreter acting as a cultural broker seems to be strongly tied with the clinician’s preconceived ideas of what the role of the interpreter is. Although most appreciated the cultural brokering, there were still other clinicians who only wanted what the client said verbatim regardless of whether the interpreter understood it or not, and without any clarification or cultural information added.

Interpreters and therapists agree that the best framework for effective cross-language therapy is a relationship that is collaborative and based on trust.

The second category of Becher and Wieling’s research is, “The Relationship Matters.” Based on the interviews, it seems that the relationship between interpreters and clinicians plays a large role in the comfort level of their interaction. Most interpreters said that their experience with the clinician varied widely depending on whether the interpreter was a staff interpreter or an agency-based interpreter. Most staff-interpreters voiced that they felt “empowered” and “respected” by therapists and clinicians. However, most agency-based interpreters felt they had to “maintain strong

professional boundaries.” *Most interpreters and clinicians feel most comfortable working together when they have had time to develop a trusting relationship.*

The last category in Becher and Wieling’s research is, “Who Has the Power?” Power dynamics in a relationship can be difficult to figure out. According to the interviews conducted, power within a clinician and interpreter relationship was best navigated if that relationship was a positive in nature. Interestingly, clinicians were confident and overt about the power they held and even the power of the interpreter. Many interpreters, however, did not seem to recognize their power explicitly. Overall, most interviewees acknowledged that the power is shared.

This article, points to the complexities and necessity of using interpreters in clinical mental health settings. Power and privilege undoubtedly play a large role in the relationship between service providers and the clinical encounter. It is imperative that interpreters and clinicians have a relationship based on collaboration and trust to attain the best outcomes in patient treatment. Relationships are best formed if the same interpreter is used over the course of treatment, and the service providers respectfully discuss the plan of action in pre and post session debriefings. Trusting relationships lead to interpreters feeling empowered and able to “speak out” as a cultural broker. Cultural information can help inform clinicians as to the best course of action in treating a patient. 

Major Victory for Persons with Disabilities and Their Families

Washington, D.C. – Dec. 17, 2014) Congress passed the [Achieving a Better Life Experience \(ABLE\) Act of 2014 by a large bi-partisan vote](#). First introduced in 2006, and subsequent sessions of Congress, the ABLE Act will allow people with disabilities (with an age of onset up to 26 years old) and their families the opportunity to create a tax-exempt savings account to cover qualified expenses.

Before leaving for vacation, President Obama signed the ABLE Act. With his signature, the president has paved the way for people with disabilities to open tax-free savings accounts where they can save up to \$100,000 without risking eligibility for Social Security and other government programs. Individuals can keep their Medicaid coverage no matter how much money is accrued in an ABLE account.

Modeled after 529 college savings plans, interest earned on savings will be tax-free. Funds accrued in the accounts can be used to pay for education, health care, transportation, housing and other expenses.



2015 MENTAL HEALTH INTERPRETER INSTITUTE

AUGUST 3-7, 2015

MONTGOMERY, ALABAMA

MHIT Is:

A 40-hour course designed to provide a sound basis for interpreters to work effectively in mental health settings as part of a treatment team associated with Mental Illness and Treatment, Interpreters' Roles, Tools, and Resources, Severe Language Dysfluency and Visual Gestural Communication/CDIs/Interpreters who are Deaf, Psychiatric Emergencies, Confidentiality Ethics and Laws, Support Groups and Community Mental Health Services, Psycholinguistic Errors and Demand Control Schema for Interpreting Applied to Mental Health.

The Institute is a collaborative effort between the Alabama Department of Mental Health's Office of Deaf Services ADARA and Troy University Interpreter Training Program

PRESENTERS INCLUDE:

Bob Pollard, Robyn Dean, Roger Williams, Steve Hamerdinger, Charlene Crump, Brian McKenny, Shannon Reese, et. al.

COST OF TRAINING:

	Thru Feb 15	Feb 16 - April 13	April 13 – May 31	After May 31	Day Rate
Participants	\$290	\$340	\$390	\$425	\$100
Alumni	\$165	\$215	\$265	\$310	\$85

A MINIMUM OF 4.0 RID CEUS WILL BE OFFERED

**FOR COMPLETE INFORMATION AND TO DOWNLOAD AN
APPLICATION VISIT WWW.MHIT.ORG**

As I See It

(Continued from page 8)

In order to “protect” us the government will put us in more danger. Good plan.

This is one more drip in the perpetual water torture of bureaucratic indifference – if not outright hostility – to what we think is best for us. Apache Trails – drip. Many states no longer have Vocational Rehabilitation Counselors who are ASL-fluent – drip. Mental health services for deaf people being lost into monolithic (and monolingual) integrated healthcare programs – drip. But, hey! The great “THEY” know what’s best for us, right?

I feel a bit like the First Nations chief who supposedly said, “When told the reason for daylight savings time the Old Indian said, “Only the government would believe that you could cut a foot off the top of a blanket, sew it to the bottom, and have a longer blanket.”

Remember how “inclusion” was supposed to solve all our problems? I have yet to see a problem deaf people face that has not been made worse by some bureaucrat in Washington. Whatever happened to “person-centered planning”?

“Where do you want to live?” asks Barry Bureaucrat.

“In a place with other deaf people who use ASL,” says Deaf Donald.

“You can’t do that. It is against your best interest. You have to be with non-deaf people,” replies Barry Bureaucrat.

“But I can communicate better with other deaf people.” Said Deaf Donald.

“I know what’s best for you,” said Barry Bureaucrat.

Ah yes. Infantilize deaf people. We can’t make our own decisions, you see.

As I See It, deaf people deserve to have our choices respected, without being told where we can and cannot live because of “inclusion”. We are the ones who should decide what’s best for us not some SHP* that has probably never had a conversation with a deaf person in her or his life. 🤝

(*Stupid Hearing Person)

Thornsberry Joins ODS Staff as Regional Therapist

(Continued from page 3)

desire to become DSAT Consumer Trainers. This curriculum has rich information about how to advocate for personal needs, to request accommodations, and to find resources.

While working as a case manager, Thornsberry was involved with the Utah State Rehabilitation Taskforce team to develop Self Advocacy curriculum applicable to Vocational Rehabilitation clients. She also had an opportunity to be part of Utah’s Empowered Deaf Parenting curriculum which she helped develop. This curriculum incorporates effective techniques, theories, research and information from widely used parenting curriculums to fit the cultural and linguistic needs of Deaf and Hard of Hearing people. She has been active in other organizations, Sego Lily Center for the Abused Deaf, Beehive Chapter of Gallaudet University Alumni Association (Utah chapter), and various event planning committees.

Thornsberry and her husband Brian have a daughter, Stormi, who is 19 and a junior at college and son, Ty, who is 8 and in 2nd grade. She loves outdoor activities, especially camping, hiking, biking, and running, and loves doing art and crafts.

“I am excited to be back to family roots in Alabama and I look forward to working with everyone at the Alabama Department of Mental Health and Office of Deaf Services,” Thornsberry told us. Her office is located at Wellstone Behavioral Health in Huntsville. Those wanting to set up an appointment with her or to simply say hello are invited to email her at kim.thornsberry@mh.alabama.gov or VP at 256-217-4308.



Research Study

Conducted by Jill Meyer and Vanessa Hinton
Auburn University
Department of Special Education, Rehabilitation, and Counseling

If you are **between the ages of 19 and 25**, you are invited to participate in a research study to provide information about **working, living, and participating in the community**.

This survey is voluntary, so you can quit anytime you want. You may skip any questions that make you uncomfortable. The survey will take about 30 minutes. Any information you provide is **confidential** and **does not identify you** in any way.

There is a raffle for one of four \$50 Visa Gift Cards for participating in this Survey. We greatly appreciate your time and willingness to participate.

[Click the Link Below to Participate](https://auburn.qualtrics.com/SE/?SID=SV_bjfl1ivKDcgJHD)
https://auburn.qualtrics.com/SE/?SID=SV_bjfl1ivKDcgJHD

PSYCHOLOGIST I (Office of Deaf Services)
SALARY RANGE: (\$52,663.20- \$80,287.20)

JOB LOCATION: Department of Mental Health
(Tuscaloosa Bryce Hospital Complex)

QUALIFICATIONS: Graduation from an accredited college or university with a Doctorate degree in Psychology.

SPECIAL REQUIREMENTS: Possession of or eligibility for licensure as issued by the Alabama Board of Examiners in Psychology. **Proficiency in American Sign Language at "Advanced Plus" or higher** level of signing skills as measured by a recognized screening process, such as SLPI.

The employee in this position will be responsible for providing clinical services to deaf and hard of hearing (D/HH) consumers at our Tuscaloosa facilities and in West Alabama. This position works within the Office of Deaf Services, Division of Mental Health and Substance Abuse Services, providing culturally and linguistically appropriate psychological testing and assessment of deaf consumers throughout the state. Works with inter-disciplinary treatment teams in the development, implementation, and review of patient treatment plans. Conducts group, individual, and family therapy. Develops, implements, reviews, and supervises behavioral and milieu treatment programs. Maintains accurate documentation as required by policy as well as departmental and mental health center guidelines. Performs related duties as assigned.

Please request complete announcement <http://www.mh.alabama.gov/ADHR/ExemptJobs/Search.aspx>. Questions can be directed to Steve Hamerdinger, Director of Deaf Services. Steve.hamerdinger@mh.alabama.gov or VP (334) 239-3558.

Important Position Announcements

**Mental Health Specialist II
(Regional Therapist)**

SALARY RANGE:
74 (\$39,290.40 - \$59,517.60)

Work Location: Deaf Services Region III Office Mobile, Alabama

QUALIFICATIONS: Master's degree in a human services field, plus experience (24 months or more) working with deaf individuals in a human service setting. (See full announcement for details)

NECESSARY SPECIAL REQUIREMENTS: Must have near native-level signing skills equal to Advanced Plus level or higher in American Sign Language (ASL) as measured by a recognized screening process as the Sign Language Proficiency Interview (SLPI). Must have a valid driver's license to operate a vehicle in the State of Alabama.

This is highly responsible professional work within the Office of Deaf Services involving direct clinical services supporting deaf consumers and community mental health programs that have deaf consumers in their caseloads.

The person in this position will be responsible for providing direct clinical services to deaf individuals, advocates with other mental health agencies in support of deaf individuals who need services, arranges or supervises the arrangement of interpreter services to support service provision for deaf individuals, and serves as a liaison between the Alabama Department of Mental Health and community service providers located in the Coordinator's service region. This position will work under the direct supervision of the Director of the Office of Deaf Services.

Please request complete announcement <http://www.mh.alabama.gov/ADHR/ExemptJobs/Search.aspx>. Questions can be directed to Steve Hamerdinger, Director of Deaf Services. Steve.hamerdinger@mh.alabama.gov

Current Qualified Mental Health Interpreters

Becoming a *Qualified Mental Health Interpreter* in Alabama requires a rigorous course of study, practice, and examination that takes most people nearly a year to complete. It involves 40 hours of classroom time, 40 hours of supervised practica and a comprehensive examination covering all aspects of mental health interpreting. (*Alabama licensed interpreter are in Italics*) *Denotes QMHI- Supervisors

Charlene Crump, Montgomery*
Denise Zander, Wisconsin
Nancy Hayes, Remlap
Brian McKenny, Montgomery*
Dee Johnston, Talladega
Lisa Gould, Mobile
Gail Schenfisch, Wyoming
Dawn Vanzo, Huntsville
Wendy Darling, Montgomery
Pat Smartt, Sterrett
Lee Stoutamire, Mobile
Frances Smallwood, Huntsville
Cindy Camp, Piedmont
Lynn Nakamoto, Hawaii
Roz Kia, Hawaii
Jamie Garrison, Wisconsin*
Kathleen Lamb, Wisconsin
Dawn Ruthe, Wisconsin
Paula Van Tyle, Kansas
Joy Thompson, Ohio
Judith Gilliam, Talladega
Stacy Lawrence, Florida

Sandy Peplinski, Wisconsin
Katherine Block, Wisconsin*
Steve Smart, Wisconsin
Stephanie Kerkvliet, Wisconsin
Nicole Kulick, South Carolina
Rocky DeBuano, Arizona
Janet Whitlock, Georgia
Sereta Campbell, Tuscaloosa*
Thai Morris, Georgia
Lynne Lumsden, Washington*
Tim Mumm, Wisconsin
Patrick Galasso, Vermont
Kendra Keller, California*
June Walatkiewicz, Michigan
Teresa Powers, Colorado
Melanie Blechl, Wisconsin
Sara Miller, Wisconsin
Jenn Ulschak, Tennessee
Kathleen Lanker, California
Debra Barash, Wisconsin
Tera Vorphal, Wisconsin
Julayne Feilbach, New Mexico

Sue Gudenkauf, Wisconsin
Tamera Fuerst, Wisconsin
Rhiannon Sykes-Chavez, New Mexico
Roger Williams, South Carolina*
Denise Kirby, Pennsylvania
Darlene Baird, Hawaii
Stacy Magill, Missouri
Camilla Barrett, Missouri
Angela Scruggs, Tennessee
Andrea Nelson, Oregon
Michael Klyn, California
Cali Luckett, Texas
Mariah Wojdacz, Georgia
David Payne, North Carolina
Lori Milcic, Pennsylvania
Amber Mullett, Wisconsin
Nancy Pfanner, Texas
Jennifer Janney, Delaware
Stacie Bickel, Missouri
Tomina Schwenke, Georgia

DEAF CARE WORKER (Bryce Hospital Tuscaloosa)
SALARY RANGE: 50 (\$21,722.40 - \$30,724.80)

Works primarily in a specialized psychiatric unit providing care, habilitation, and rehabilitation of deaf and hard of hearing (D/HH) patients with co-occurring disorders of mental illness and chemical dependency in a state mental health hospital. Performs basic nursing care and assist patients with personal hygiene and activities of daily living. Observes patients closely and documents patients' physical and mental condition. Maintains the security of patients. Accompanies patients off unit to hospital activities, functions, and off hospital grounds to medical appointments and field trips. Communicates with D/HH patients in sign language. Performs assigned work under supervision of professional nurses and LPNs with instructions from physicians. Performs related work as required.

NECESSARY SPECIAL REQUIREMENTS: Must be 18 years of age. Graduation from a standard high school or GED equivalent. Possession of a valid Alabama Driver's License. Proficiency in American Sign Language (ASL) at "native" or "near native fluency" level of signing skills as measured by a recognized screening process, such as SLPI/SCPI at the "Advanced" level or higher.

For more information please contact:
Steve Hamerdinger, Director, Office of Deaf Services
Alabama Department of Mental Health
100 North Union Street
Montgomery, AL 36130
Steve.hamerdinger@mh.alabama.gov
(334) 239-3558 (Voice/VP)

MENTAL HEALTH TECHNICIANS Deaf Services Group Home
(Clanton, AL) SALARY RANGE: Competitive

Positions Available: all shifts Candidates must possess proficiency in ASL

Duties:

- Provide personal, direct care for consumers with mental illness diagnoses who are also deaf or hard-of-hearing.
- Pass medications under the direction of a Medical Assistance LPN.
- Provide transportation to consumer appointments.
- Provide basic living skills training and assistance.
- Provide communication assistance to the consumers through the use of Sign Language or language of the consumer's preference. Ensure that consumers have access to assistance by a qualified interpreter.
- Maintain policy of confidentiality.
- Qualifications:
 - High School Diploma or equivalent required
 - Current AL Driver License and safe driving record
 - Prior experience serving clients who are deaf or hard-of-hearing preferred.
 - Prior experience working with clients with mental illness or intellectual disabilities preferred.

For more information go to application webpage or contact:

Lori Redding, MHA
Director of Human Resources
Chilton-Shelby Mental Health Center
lredding@chiltonshelby.org
office: 205/668-4308 cell: 205/310-6706

From the Editor

(Continued from page 2)

out of the field altogether as deaf people fill more and more of the treatment roles. I used to think of the day when interpreting in group meant supporting the deaf social worker or psychologist when there were hearing clients.

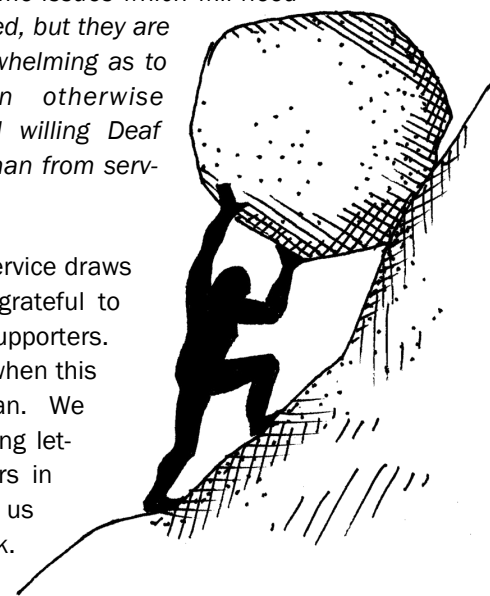
Ah well. Just wanted to warn you to watch for his application and don't put it to the side! He won't be able to keep up with Roger Williams who is both smart and clever, but should be right in there with Bob Pollard, who is brilliant but just funny.

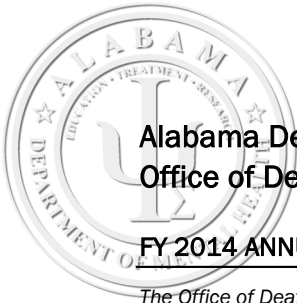
All the best to you and please pass my warm regards along,

Another came from Kathleen Fiorini, a social work intern some years ago.

Good articles throughout, y'all! I particularly enjoyed Brian's and SH's articles. Steve, thanks for sharing your personal perspective on Deaf in the military. In light of illegal aliens being allowed to serve, how can we justify shutting our own people out?!!! There are extremely knowledgeable Deaf who would fit right in areas such as design, healthcare, strategy, provision, etc.; there are young Deaf who dream of marching in their uniform for the protection of America's citizens. Yes, there are some issues which will need to be resolved, but they are not so overwhelming as to prevent an otherwise healthy and willing Deaf man or woman from serving.

As another year of service draws to a close, we are grateful to our friends and supporters. They keep us going when this work seems Sisyphean. We look forward to getting letters from our readers in the coming year. Let us know what you think. We won't bite... not hard ,





Alabama Department of Mental Health Office of Deaf Services

FY 2014 ANNUAL REPORT

The Office of Deaf Services is responsible for developing and implementing programs that meet the linguistic and cultural needs of DMH's consumers who are Deaf or hard of hearing. Services are designed to be affirmative and supporting to consumers who traditionally have not been able to benefit from services offered by the department.

Responsible for:

- Ensuring that Alabamians who are deaf or hard of hearing have access to a full array of linguistically and culturally appropriate services, including various community-based service options.
- Managing an acute in-patient services unit for people who are deaf. This unit will be designed to treat people with co-occurring mental illness and substance abuse problems. It will be the only unit of its kind in the country. The unit will also serve as a center of excellence for the entire state and unit staff will be available to assist with special needs of consumer with hearing loss wherever they turn up in the system.
- Overseeing regional coordinators of Deaf Services who are located in Huntsville, Birmingham, Montgomery, and Mobile. Services are delivered through contracts with community mental health centers. Regional coordinators work with local mental health centers to coordinate the delivery of linguistically and culturally appropriate services.
- Providing consultation and technical assistance to the facilities and providers when requested. Areas of expertise include, deafness and mental health (particularly as it applies to clinical practice), the Americans with Disabilities Act and other disability focused legislation, interpreting and clinical service using interpreters,
- Collaborating with staff from the Division's sister service Divisions on improving their services to people who are deaf or hard of hearing.
- Training staff of both the department's facilities and its community providers on deafness and mental health issues.
- Monitoring the quality of services provided to consumers who are deaf, including interpreter services.
- Conducting training for mental health interpreters. The Alabama Mental Health Interpreter Training (ALMHIT) program is an 80 hour course of study (40 hours classroom work, 40 hours supervised practicum) for advanced interpreters who wish to work in mental health settings.
- Community outreach and education to both the Deaf Community and the general community in Alabama through the use of media, conducting workshops and town hall discussions, participation and sponsorship of Deaf Community events and activities.

Highlights Of the Year:

- The Office of Deaf Services is nationally recognized as one of the outstanding mental health programs for deaf people. Agencies around the country seek assistance from ODS. Technical assistance and consultation was provided to 3,668 people and programs.
- The Office of Deaf Services provided community- based services directly to 1,154 consumers with 6,025 consumer contacts throughout the year.
 - Last year 1,806 people with hearing loss were reported in community service programs. Of these, 161 were deaf. ODS oversees the operation of five group homes as well as several special supported living projects.
 - Three-bed home in Woodville
 - Two three-bed homes in Birmingham
 - Six-bed home in Clanton
 - Three-bed home in Mobile
 - In an average month ADMH served 27 hard of hearing and 7 deaf people in the state facilities. With the closure of the Bailey Deaf Unit, most deaf consumers are served on Unit 7 at Bryce Hospital.
 - With the retirement in June of long-time psychologist, France Ralston, there currently are no clinicians based at Bryce to work with those consumers. Recruitment is occurring but as of report time, there have been no qualified applicants.
 - ODS has three communication access team members based in Tuscaloosa at this time.
 - There are 4 Deaf Care Workers authorized to Bryce. There are several vacancies at this time.
- Last year, 8,272.75 hours of interpreter services were provided for deaf consumers. Of this, 6,889.5 hours were provided by staff interpreters. This is in spite of having an interpreter vacancy the entire year.
- This year, for the first time, ODS has had the lead responsibility for ensuring communication access for deaf and hard of hearing consumers of substance abuse treatment services. To this end, the office provided 698.75 hours of interpreter services, plus limited direct clinical services provided by regional therapists.
- ODS is partnering with AIDB and ADRS on Sign Language Proficiency Interviews. ODS trains staff from both agencies leading to consistency and fidelity to the national standards.
 - We provided Sign Language Proficiency Interviews for the Interpreter Training program at Troy University. We also assisted with communication access to events on campus.
 - There are now two Troy Interpreter Training Program students receiving DMH stipends. They will come to work for mental health programs on graduation.
- Charlene Crump is working with Roger Williams to standardize communication assessments used in Alabama and South Carolina. This would lead to a national model on how to measure and assess language dysfluency in deaf people with mental illness.
- Several internships were provided this year for both interpreters (2) and social work (1).
- ODS is working to develop spoken language standards and RFP language for DMH.
- Several ODS staff members earned significant recognition for their work
 - Vyrion Kinson was awarded for Golden Hands Award by SC Association of the Deaf and the National Association of the Deaf for service to Deaf People.
 - Brian McKenny was named Interpreter of the Year for the Council of Organizations Serving Deaf Alabamians.
 - Steve Hamerdinger was invited to give the keynote address at the NASW-Michigan annual social work conference in Lansing.

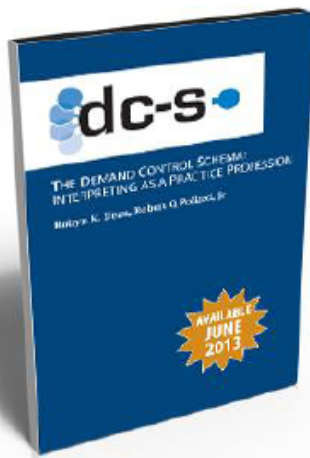
The seventh annual Clinical Training, a project of MHIT, drew 138 participants. This training is designed to give clinicians skills in working with deaf consumers and interpreters.

Mental Health Interpreter Training Project held its 12th week-long Interpreter Institute August 4-8, 2014 at Troy University at Montgomery. The annual Institute, with attendance, was "sold out" months before the opening session. Altogether 85 individuals from 28 different states and 2 foreign countries were on hand. The total attendance with all staff, volunteers and participants was 115. Since the first Interpreter Institute, 720 different people have been trained, an average of 65 new people every year.

AVAILABLE NOW!

The Demand Control Schema: Interpreting as a Practice Profession

by
Robyn K. Dean
and
Robert Q Pollard, Jr.



Dean and Pollard have been developing the demand control schema (DC-S) and their practice-profession approach to community interpreting since 1995. This textbook is the culmination of nearly two decades of work, as it evolved over the course of 22 articles and book chapters and nine DC-S research and training grants. Designed primarily for classroom use in interpreter education programs (IEPs), interpreting supervisors, mentors, and practitioners also will find this book highly rewarding. IEPs could readily use this text in introductory courses, ethics courses, and in practicum seminars. Each of its ten chapters guides the reader through increasingly sophisticated descriptions and applications of all the key elements of DC-S, including its theoretical constructs, the purpose and method of dialogic work analysis, the schema's teleological approach to interpreting ethics, and the importance of engaging in reflective practice, especially supervision of the type that is common in other practice professions. Each chapter concludes with a class activity, homework exercises, a check for understanding (quiz), discussion questions, and an advanced activity for practicing interpreters. The first page of each chapter presents a list of the chapter's key concepts, preparing the reader for an efficient and effective learning experience. Numerous full-color photos, tables, and figures help make DC-S come alive for the reader and assist in learning and retaining the concepts presented. Formal endorsements from an international panel of renown interpreter educators and scholars describe this text as "aesthetically pleasing," praising its "lively, accessible style," its "logic and organization," and referring to it as an "invaluable resource" with international appeal to "scholars and teachers." Spoken language interpreters also are proponents of DC-S and will find the material in this text applicable to their education and practice, as well.

CONTENTS:

- | | |
|-------------------------------------|--|
| Chapter 1: Demands of Interpreting | Chapter 6: Teleology and Practice Values |
| Chapter 2: Controls of Interpreting | Chapter 7: Demand Constellations |
| Chapter 3: DC-S Rubric | Chapter 8: Consequences |
| Chapter 4: EIPI Categories | Chapter 9: Dialogic Work Analysis |
| Chapter 5: D-C Interactions | Chapter 10: The Reflective Practice of Supervision |

To order, visit our website:
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*Going for the Gold
ADARA 2015
Rochester, NY*



A photograph of the Rochester skyline across the River Rafters. The skyline includes several tall buildings, including the Rochester City Hall and the Rochester Convention Center. The river is in the foreground, and a bridge is visible in the middle ground.

APRIL 21-25, 2015

**Radisson Riverside Hotel
Rochester, NY**

***More Information available at
www.adara.org***



From Our Place to Yours...

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Joyce Canana

Don Vay

Shirley Sauter

Kathleen Allen

Norma

Kimberly Thompson

Bryce

Paul Hambrick

Wishing you days that are merry and bright
From all of us at the Office of Deaf Services